RETIREE BENEFIT WAIVER FORM

*This is to certify that I _____ have elected **NOT** to participate as a primary policyholder in the following WSSC Water benefit plans.*

I understand that if I cancel my health, or dental or vision plan, I will NOT be eligible to apply for these plans in the future.

*Please fill in the plan name below that you wish to **CANCEL**:*

- *my Health Insurance Plan: _____*
- *my Dental Insurance Plan: _____*
- *my Vision Insurance Plan: _____*

Retiree Name: _____
(please print)

Home Address: _____

Home/Cell Phone Number: _____

Please return the completed form to:

WSSC Human Resources Office, Benefits Division
14501 Sweitzer Lane, Laurel, MD 20707
or scan & email to HR_benefits@wsscwater.com
or fax: 301-206-8713

*Signature:*_____ *Date:* _____